

CORE 400 LLC
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Nevada City, California 95959

Notice of Independent Review Decision

DATE OF REVIEW: OCTOBER 30, 2008

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

Lumbar Discogram and CT Scan of the Lumbar Spine

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

MD, Board Certified Orthopedic Surgeon

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- Upheld (Agree)
 Overturned (Disagree)
 Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether or not medical necessity exists for each of the health care services in dispute.

The reviewer finds that medical necessity does not exist for Lumbar Discogram and CT Scan of the Lumbar Spine.

INFORMATION PROVIDED TO THE IRO FOR REVIEW

Office notes, PA-C, 06/06/07
MRI, 06/18/07
Office notes, Dr. , 07/03/07, 08/02/07
EMG, 07/09/07
Office notes, Dr. , 08/08/07, 09/24/07
FCE, 09/12/07
ESI, 09/14/08, 10/19/07, 09/15/08, 09/23/08
Psychosocial Evaluation, 09/27/07
Office note, Dr. 11/02/07

IME, Dr. , 11/16/07
Office note, Dr. , 05/19/08
MRI lumbar spine, 08/04/08
Dr. I, 09/11/08
Dr. , 09/23/08
Office note, Dr. 06/25/07
Computerized Muscle Testing, 09/24/07, 11/05/07
TWCC, 04/11/08
ODG Guidelines and Treatment Guidelines

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a xx year old female injured on xx/xx/xx when a patient passed out as she was holding him up. She has been treated for low back and bilateral leg pain with medications, therapy, chiropractic and injections. Her most recent diagnosis would be herniation with radiculopathy.

The 06/18/07 MRI of the lumbar spine showed an L3-4 right foraminal herniation with a radial annular tear narrowing the neural foramina. There was L4-5 disc dessication with a left herniation that flattened the thecal sac and the L5 nerve root as well as mild bilateral foraminal encroachment. At L5-S1 was an annular disc bulge with facet arthrosis and mild bilateral foraminal narrowing. A 07/09/07 EMG documented that it was non specific but compatible with L4-5 root compression/irritation.

On 08/08/07 Dr. evaluated the claimant noting that she had impairments with activities of daily living due to back and leg pain on the left. On examination there was tenderness over the spinous processes at L3, 4, 5 and S1 also facet tenderness more at L3-4 and 4-5. There was a positive Faber. Reflexes were 2 plus and strength 5/5. There was slight dysesthesia in both legs in L4 and 5. He recommended and gave two epidural steroid injections with some brief benefit in leg pain.

The claimant was evaluated on 11/02/07 by Dr. , neurology and psychiatry, for back and bilateral leg pain, numbness and weakness. On examination there was limited motion and severe spasm. There was bilateral sciatic notch tenderness. She had 5/5 strength but decreased light touch in L4-5 and absent ankle jerks. He felt she was unable to work, had failed conservative care and would possibly be a candidate for surgery and discogram.

On 11/16/07 Dr. saw the claimant for an Independent Medical Evaluation. She reported primarily low back pain with bilateral leg pain more right to the foot and toes. On examination there was limited motion. She was able to heel and toe stand. Reflexes were brisk at the knees and ankles. There was no sensory loss. He did not feel she had reached maximal medical improvement and recommended referral to a neurosurgeon, off work and work up and possible surgical intervention.

On 05/19/08 Dr. saw the claimant for a Designated Doctor Evaluation. The examination showed a positive straight leg raise with decreased sensation in the right medial foot and lower leg in L4-5 and L5-S1. He felt that she would likely need fusion.

A 08/04/08 MRI of the lumbar spine documented minimal bulging at L3-4. There was an L4-5 left annular tear with focal disc protrusion with compression on the L5 nerve root before it left

the sleeve. The bony canal and foramina were widely patent. The L5-S1 foramina and canal were patent and there was mild disc bulging.

A discogram was requested and has been denied twice on peer review.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION

The requested lumbar discogram and post discogram CT scan is not medically necessary based on review of this medical record.

This claimant has back and leg symptoms and has undergone a couple of different MRI's documenting an L4-L5 left focal disc protrusion with L5 nerve root compression. There is no documentation in the medical record of structural instability and it would appear that a discogram is being requested to determine whether or not this patient needs lumbar spine fusion.

ODG guidelines document that discograms are not recommended and question their use for preoperative planning. In this case, there is no clear documentation or medical indication for lumbar fusion in that there is no evidence of a tumor, infection, or structural instability, and no clear documentation as to what new information a discogram is going to provide in this case.

The reviewer finds that medical necessity does not exist for Lumbar Discogram and CT Scan of the Lumbar Spine.

Official Disability Guidelines Treatment in Worker's Comp 2008, Low Back-Discography Not recommended. In the past, discography has been used as part of the pre-operative evaluation of patients for consideration of surgical intervention for lower back pain. However, the conclusions of recent, high quality studies on discography have significantly questioned the use of discography results as a preoperative indication for either IDET or spinal fusion.

Discography is Not Recommended in ODG.

Patient selection criteria for Discography if provider & payor agree to perform anyway:

- o Back pain of at least 3 months duration
- o Failure of recommended conservative treatment including active physical therapy
- o An MRI demonstrating one or more degenerated discs as well as one or more normal appearing discs to allow for an internal control injection (injection of a normal disc to validate the procedure by a lack of a pain response to that injection)
- o Satisfactory results from detailed psychosocial assessment (discography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided)
- o Intended as a screen for surgery, i.e., the surgeon feels that lumbar spine fusion is appropriate but is looking for this to determine if it is not indicated (although discography is not highly predictive) ([Carragee, 2006](#)) NOTE: In a situation where the selection criteria and other surgical indications for fusion are conditionally met, discography can be considered in preparation for the surgical procedure.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- INTERQUAL CRITERIA
- MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- MILLIMAN CARE GUIDELINES
- ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- TEXAS TACADA GUIDELINES
- TMF SCREENING CRITERIA MANUAL
- PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)